General

Guideline Title

Transition between inpatient mental health settings and community or care home settings.

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Transition between inpatient mental health settings and community or care home settings. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug 30. 34 p. (NICE guideline; no. 53).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health. See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Although most of the recommendations in this guideline cover both planned and unplanned admissions, some (like those on pre-admission planning) are only applicable to planned admissions. If an admission is unplanned, then these recommendations should be applied at the soonest possible point after admission, if appropriate to the person's individual circumstances.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation) and is defined at the end of the "Major Recommendations" field.

Overarching Principles

Ensure the aim of care and support of people in transition is person-centred and focused on recovery.

Work with people as active partners in their own care and transition planning. For more information, see the section on relationships and communication in NICE's guideline on service user experience in adult mental health services.

Support people in transition in the least restrictive setting available (in line with the Mental Health Act Code of Practice).

Record the needs and wishes of the person at each stage of transition planning and review.

Identify the person's support networks. Work with the person to explore ways in which the people who support them can be involved throughout their admission and discharge.

Enable the person to maintain links with their home community by:

- Supporting them to maintain relationships with family and friends, for example, by finding ways to help with transport
- Helping them to stay in touch with social and recreational contacts
- Helping them to keep links with employment, education and their local community

This is particularly important if people are admitted to mental health units outside the area in which they live.

Mental health services should work with primary care, local authorities and third sector organisations to ensure that people with mental health problems in transition have equal access to services. This should be based on need and irrespective of:

- Gender
- Sexual orientation
- Socioeconomic status
- Age
- Disability
- Cultural, ethnic and religious background
- Whether or not they are receiving support through the Care Programme Approach
- Whether or not they are subject to mental health legislation

Give people in transition comprehensive information about treatments and services for their mental health problems at the time they need it. If required, provide information:

- In large-print, braille or Easy Read format
- By audio or video
- In translation

For more information, see the section on care and support across all points on the care pathway in NICE's guideline on service user experience in adult mental health .

Before Hospital Admission

Planning and Assessment

Mental health practitioners supporting transition should respond quickly to requests for assessment of mental health from:

- People with mental health problems
- Family members
- Carers
- Primary care practitioners (including general practitioners [GPs])
- Specialist community teams (for example, learning disability teams)
- Staff such as hostel, housing and community support workers

Assessments for people in crisis should be prioritised.

If admission is being planned for a treatment episode involve:

- The person who is being admitted

Their family members, parents or carers
Community accommodation and support providers

When planning treatment for people being admitted, take account of the expertise and knowledge of the person's family members, parents or carers.

Allow more time and expert input to support people with complex, multiple or specific support needs to make transitions to and from services, if necessary. This may include:

Children and young people
People with dementia, cognitive or sensory impairment
People on the autistic spectrum
People with learning disabilities and other additional needs
People placed outside the area in which they live

For planned admissions, offer people an opportunity to visit the inpatient unit before they are admitted. This is particularly important for:

Children and young people
People with dementia, cognitive or sensory impairment
People on the autistic spectrum
People with learning disabilities and other additional needs
People placed outside the area in which they live

If it is not possible for the person to visit the inpatient unit that they will be admitted to in advance, consider using accessible online and printed information to support discussion about their admission.

During admission planning, record a full history or update that:

Covers the person's cognitive, physical and mental health needs
Includes details of their current medication
Identifies the services involved in their care

For more information, see the section on medicines reconciliation in the NGC summary of NICE's guideline Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.

If more than one team is involved in a person's transition to, within and from a service, ensure there is ongoing communication between the inpatient team and other relevant teams that include:

Community health or social care providers, such as:
- The community mental health team
- The learning disability team
- Teams that work with older people
- Child and adolescent mental health services (CAMHS)
- Housing support teams
- General hospital or psychiatric liaison teams

Crisis Plans

Support people who have had more than one admission to develop a crisis plan as part of their care planning process. This should include:

Relapse indicators and plans
Who to contact in a crisis
Coping strategies
Preferences for treatment and specific interventions
Advance decisions

For more information, see the section on community care in NICE's guideline on service user experience in

adult mental health services .

Hospital Admission

General Principles

Start building therapeutic relationships as early as possible to:

- Lessen the person's sense of being coerced
- Encourage the person to engage with treatment and recovery programmes and collaborative decision-making
- Create a safe, contained environment
- Reduce the risk of suicide, which is high during the first 7 days after admission

This is particularly important for people who have been admitted in crisis.

Practitioners involved in admission should refer to crisis plans and advance statements when arranging care.

Advance decisions must be followed in line with the Mental Capacity Act 2005 .

At admission, offer all people access to advocacy services that take into account their:

- Language and communication needs
- Cultural and social needs
- Protected characteristics (see the GOV.UK page about discrimination).

Health and social care practitioners admitting someone with cognitive difficulties should try to ensure the person understands why they have been admitted.

During admission, discuss with the person:

- Any strategies for coping that they use
- How they can continue to use, adapt and develop positive coping strategies on the ward

Start discharge planning at admission or as early as possible when in crisis (for more information, see the "Hospital Discharge" section below).

For recommendations on assessing and treating people who have been detained under the Mental Health Act, see Section 1.8 of NICE's guideline on service user experience in adult mental health services .

For recommendations on crisis, including crisis admissions, see Section 1.5 in NICE's guideline on service user experience in adult mental health services .

Out-of-Area Admissions

If the person is being admitted outside the area in which they live, identify:

- A named practitioner from the person's home area who has been supporting the person
- A named practitioner from the ward they are being admitted to

The named practitioners from the person's home area and the ward should work together to ensure that the person's current placement lasts no longer than required. This should include reviewing the person's care plan, current placement, recovery goals and discharge plan at least every 3 months, or more frequently according to the person's needs. This could be done in person or by audio or videoconference.

For people admitted to hospital outside the area in which they live, take into account the higher risk of suicide after discharge at all stages of the planning process (see the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness). This should include:

- Assessing the risk

- Discussing with the person how services can help them to stay safe
- Discussing with the person's family members, parents or carers how they can help the person to stay safe

Legal Status of Person Being Admitted

The senior health professional responsible for the admission should tell the person being admitted about their legal status at the point of admission. They should:

- Use clear language
- Discuss rights and restrictions with the person
- Provide written and verbal information
- Make the discussion relevant to the ward the person is being admitted to
- Explain whether they are under observation and what this means (see the "Observations and Restrictions" section below)

A senior health professional should ensure that discussions take place with the person being admitted to check that:

- They have understood the information they were given at admission
- They know they have a right to appeal, and that information and advocacy can be provided to support them to do so if they wish
- They understand that any changes to their legal status and treatment plans will be discussed as they occur

Observations and Restrictions

The admitting nurse or person responsible should tell the person what level of observation they are under and:

- Explain what being under observation means
- Explain clearly the reasons why the person is under observation and when, or under what circumstances, this will be reviewed
- Explain how they will be observed and how often
- Explain how observation will support their recovery and treatment
- Discuss with the person how their preferences will be respected and how their rights to privacy and dignity will be protected
- Offer the person an opportunity to ask questions

Ensure that restrictions, including restrictions on access to personal possessions:

- Are relevant and reasonable in relation to the person concerned
- Take into consideration the safety of the person and others on the ward
- Are explained clearly to ensure the person understands:
  - Why the restrictions are in place
  - Under what circumstances they would be changed

Addressing Personal Concerns

To support the person's transition to the ward the admitting nurse or person responsible should make the following items available if the person needs them:

- A toothbrush
- Hygiene products
- Nightwear

This is particularly important for people who have been admitted in crisis.

Give the person verbal and written information about ward facilities and routines (see the section on

hospital care in NICE's guideline on service user experience in adult mental health).

At admission, a senior healthcare professional should discuss all medication and care needs with the person being admitted. This should include:

- Physical healthcare needs
- Pregnancy, breastfeeding or the need for emergency contraception
- Advice about immediate addiction issues, treatment and support
- Mental health treatment

The admitting nurse or person responsible should discuss with the person how to manage domestic and caring arrangements and liaise with the appropriate agencies. This may include:

- People they have a responsibility to care for, such as:
  - Children
  - Frail or ill relatives
- Domestic arrangements, in particular:
  - Home security
  - Tenancy
  - Benefits
  - Home care service
  - Pets

On admission, ensure people (particularly children and young people) know who they can talk to if they are frightened or need support. For more information, see the section on hospital care in NICE's guideline on service user experience in adult mental health services .

Identify whether the person has any additional need for support, for example, with daily living activities. Work with carers and community-based services, such as specialist services for people with learning or physical disabilities, to provide support and continuity while the person is in hospital.

Support for Families, Parents and Carers throughout Admission

Identify a named practitioner who will make sure that the person's family members, parents or carers receive support and timely information (see the "Sharing Information with Families, Parents and Carers" section below).

Practitioners should start to build relationships with the person's family members, parents or carers during admission. This should be done:

- In an empathetic, reassuring and non-judgemental way
- Acknowledging that admission to hospital can be particularly traumatic for families and carers, particularly if it is the person's first admission

Arrange for parents to have protected time at an early point in the process of admitting their child to discuss the process with the relevant practitioners.

Try to accommodate parents' or carers' working patterns and other responsibilities so that they can attend meetings (if the person they care for wants this). This should include:

- Care planning meetings
- Discharge planning meetings
- Other meetings concerning the care of the person

Sharing Information with Families, Parents and Carers

Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with family members, carers and other services during the inpatient stay. For more information, see the subsection on involving families and carers in NICE's guideline on service

user experience in adult mental health services .

Throughout admission, give families, parents or carers clear, accessible information about:

- The purpose of the admission
- The person's condition (either general, or specific if the person agrees to this)
- The treatment, care and support that the person is receiving
- The inpatient unit, including:
  - The ward and the wider hospital environment
  - The practicalities of being in hospital
  - Resources that are available, including accommodation for families
  - Visiting arrangements
- Preparing for discharge

Give families, parents and carers information about support services in their area that can address emotional, practical and other needs (this is particularly important if this is the person's first admission).

Give young carers (under 18) of people in transition relevant information that they are able to understand.

Carers' Assessments

Practitioners involved in admission and discharge should always take account of carers' needs, especially if the carer is likely to be a vital part of the person's support after discharge.

Identify carers (including young carers) who have recognisable needs. If the carer wishes it, make a referral to the carer's local authority for a carer's assessment (in line with the Care Act 2014). Ensure a carer's assessment has been offered, or started, before the person is discharged from hospital.

Hospital Discharge

Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature. For more information, see NICE's guideline on service user experience in adult mental health services .

Maintaining Links with the Community

Work with the person throughout their hospital stay to help them:

- Keep links with their life outside the hospital
- Restart any activities before they are discharged

This is particularly important for people who need a long-term inpatient stay, are placed out-of-area, or who will have restricted access to the community.

Before discharge offer:

- Phased leave (the person can have trial periods out of hospital before discharge)
- Phased return to employment or education (the person can gradually build up hours spent in employment or education).

This is particularly important for people who have been in hospital for an extended period and people who have had restricted access to the community.

Before discharging a person who is in education or training, arrange a planning meeting between them and a named person from the education setting to plan their return to learning.

Education – for People under 18

Children and young people under 18 must have continued access to education and learning throughout their hospital stay, in line with the Education Act 1996 .

Before the child or young person goes back into community-based education or training:

- Identify a named worker from the education or training setting to be responsible for the transition
- Arrange a meeting between the named worker and the child or young person to plan their return

Accommodation

Before discharging people with mental health needs, discuss their housing arrangements to ensure they are suitable for them and plan accommodation accordingly. This should take into account any specific accommodation and observation requirements associated with risk of suicide.

Give people with serious mental health issues who have recently been homeless, or are at risk of homelessness, intensive, structured support to find and keep accommodation. This should:

- Be started before discharge
- Continue after discharge for as long as the person needs support to stay in secure accommodation
- Focus on joint problem-solving, housing and mental health issues

Helping the Person to Prepare for Discharge

Before discharge, offer a series of individualised psychoeducation sessions for people with psychotic illnesses to promote learning and awareness. Sessions should:

- Start while the person is in hospital
- Continue after discharge so the person can test new approaches in the community
- Cover:
  - Symptoms and their causes
  - What might cause the person to relapse, and how that can be prevented
  - Psychological treatment
  - Coping strategies to help the person if they become distressed
  - Risk factors
  - How the person can be helped to look after themselves
- Be conducted by the same practitioner throughout if possible

Consider psychoeducation sessions for all people with other diagnoses as part of planning discharge and avoiding readmission.

During discharge planning, consider group psychoeducation support for carers. This should include signposting to information on the specific condition of the person they care for.

Consider a staged, group-based psychological intervention for adults with bipolar disorder who have had at least one hospital admission and are being discharged from hospital. This should include:

- Evaluation by a psychiatrist within 2 weeks of discharge
- Three sequential sets of group sessions led by trained practitioners that focus on, respectively:
  - People's current mental health and recent experiences in hospital
  - Psychoeducation or cognitive behavioural therapy
  - Early warning signs and coping strategies

Peer Support

For people being discharged from hospital, consider a group-based, peer-delivered self-management training programme as part of recovery planning. Sessions should:

- Continue for up to 12 weeks
- Be delivered in groups of up to 12 members
- Provide an opportunity for social support

Cover:

- Self-help, early warning signs and coping strategies
- Independent living skills
- Making choices and setting goals

Consider providing peer support to people with more than one previous hospital admission. People giving peer support should:

- Have experience of using mental health services
- Be formally recruited, trained and supervised

Care Planning to Support Discharge

Ensure that there is a designated person responsible for writing the care plan in collaboration with the person being discharged (and their carers if the person agrees).

Write the care plan in clear language. Avoid jargon and explain difficult terms.

Ensure the care plan is based on the principles of recovery and describes the support arrangements for the person after they are discharged.

If a person is being discharged to a care home, involve care home managers and practitioners in care planning and discharge planning.

Ensure frequent, comprehensive review of the person's care plan and progress toward discharge.

Send a copy of the care plan to everyone involved in providing support to the person at discharge and afterwards. It should include:

- Possible relapse signs
- Recovery goals
- Who to contact
- Where to go in a crisis
- Budgeting and benefits
- Handling personal budgets (if applicable)
- Social networks
- Educational, work-related and social activities
- Details of medication (see the recommendations on medicines-related communication systems in the NGC summary of NICE guideline Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes)
- Details of treatment and support plan
- Physical health needs including health promotion and information about contraception
- Date of review of the care plan

Preparing for Discharge

Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge. The assessment should include risk of suicide (see "Follow-up Support" below). It should:

- Relate directly to the setting the person is being discharged to
- Fully involve the person
- Be shared with carers (if the person agrees)
- Explore the possibility of using a personal health or social care budget and ensure the person understands about charges for social care
- Cover aftercare support, in line with section 117 of the Mental Health Act 1983
- Cover aspects of the person's life including:
  - Daytime activities such as employment, education and leisure

- Food, transport, budgeting and benefits
- Pre-existing family and social issues and stressors that may have triggered the person's admission
- Ways in which the person can manage their own condition
- Suitability of accommodation

Recognise that carers' circumstances may have changed since admission, and take any changes into account when planning discharge.

Before the person is discharged:

- Let carers know about plans for discharge
- Discuss with carers the person's progress during their hospital stay and how ready they are for discharge
- Ensure that carers know the likely date of discharge well in advance

Follow-up Support

Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:

- Contact details, for example of:
  - A community psychiatric nurse or social worker
  - The out-of-hours service
- Support and plans for the first week
- Practical help if needed
- Employment support

Consider booking a follow-up appointment with the GP to take place within 2 weeks of the person's discharge. Give the person a written record of the appointment details.

At discharge, the hospital psychiatrist should ensure that:

- Within 24 hours, a discharge letter is emailed to the person's GP. A copy should be given to the person and, if appropriate, the community team and other specialist services.
- Within 24 hours, a copy of the person's latest care plan is sent to everyone involved in their care.
- Within a week, a discharge summary is sent to the GP and others involved in developing the care plan, subject to the person's agreement. This should include information about why the person was admitted and how their condition has changed during the hospital stay.

If the person has a learning disability, dementia or is on the autistic spectrum, the hospital team should lead communication about discharge planning with the other services that support the person in the community. This could include:

- Older people's services
- Learning disability services
- The home care service

If a person is being discharged to a care home, hospital and care home practitioners should exchange information about the person. An example might be a hospital practitioner accompanying a person with cognitive impairment when they return to the care home to help their transition (see also sharing information about a resident's medicines in the NGC summary of NICE guideline Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes).

In collaboration with the person, identify any risk of suicide and incorporate into care planning.

Follow up a person who has been discharged within 7 days.

Follow up a person who has been discharged within 48 hours if a risk of suicide has been identified.

Consider contacting adults admitted for self-harm, who are not receiving treatment in the community after discharge, and providing advice on:

- Services in the community that may be able to offer support or reassurance
- How to get in touch with them if they want to

Community Treatment Orders

Decide whether a community treatment order (CTO) or guardianship order is needed (see the Mental Health Act Code of Practice), based on:

- The benefit to the person (for example, it may be helpful for people who have had repeated admissions)
- The purpose (for example, to support the person to follow their treatment plan)
- The conditions and legal basis

Ensure that the person who will be subject to the order has the opportunity to discuss why it is being imposed. Explain:

- The specific benefit for the person
- How to access advocacy (including their entitlement to an Independent Mental Health Advocate), and what this means
- What restrictions the order involves
- When it will be reviewed
- What will happen if the person does not comply with the order, and that this may not automatically lead to readmission

Ensure that the conditions, purpose, legal basis and intended benefit of the order are explained to families, carers and others providing support.

Definitions

Strength of Recommendations

Some recommendations can be made with more certainty than others, depending on the quality of the underpinning evidence. The Guideline Committee makes a recommendation based on the trade-off between the benefits and harms of a system, process or an intervention, taking into account the quality of the underpinning evidence. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The Guideline Committee usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the Guideline Committee uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The Guideline Committee uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of people, a system, process or an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the Guideline Committee is confident that an intervention will not be of benefit for most people.

Interventions That Could Be Used

The Guideline Committee uses 'consider' when confident that a system, process or an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Clinical Algorithm(s)

A National Institute for Health and Care Excellence (NICE) pathway titled "Transition between community or care home and inpatient mental health settings overview" is available from the NICE Web site .

Scope

Disease/Condition(s)

Any mental illness or condition that requires transitions between inpatient mental health settings and community or care home settings

Guideline Category

Counseling

Management

Risk Assessment

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Other

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

- To help people who use mental health services, and their families and carers, to have a better experience of transition by improving the way it is planned and carried out
- To consider how person-centred care and support should be planned and delivered during admission to, and discharge from, mental health hospitals, irrespective of length of stay

Target Population

Children, young people, and adults with mental illnesses who are transitioning between inpatient mental health settings and community or care home settings

Note: This guideline does not include general inpatient health settings.

Interventions and Practices Considered

1. Ensuring that all care provided is person-centred and focused on recovery
2. Supporting people in transition in the least restrictive setting available
3. Recording the needs and wishes of the person at each stage of transition planning and review
4. Identification of support networks
5. Enabling the person to maintain links with their home community
6. Working with primary care, local authorities and third sector organisations
7. Giving people in transition comprehensive information about treatments and services for their mental health problems
8. Planning and assessment before hospital admission, including development of a crisis plan
9. General principles for hospital admission, following principles in the Mental Capacity Act 2005 for advance directives and in the Mental Health Act for treating people who have been detained
    - Considerations for out-of-area admissions
    - Providing the persons being admitted information about their legal status, level of observation and restrictions
    - Addressing personal concerns (e.g., hygiene, medications, pregnancy, etc.)
10. Support for families, parents, and carers and assessing needs of carers, including sharing information
11. Planning for hospital discharge
    - Maintaining community links
    - Ensuring access to education for children under age 18
    - Plan for accommodations
    - Helping the person to prepare for discharge
    - Peer support
    - Care planning to support discharge
    - Preparing for discharge
12. Providing follow-up support, including community treatment order or guardianship order

Major Outcomes Considered

Main Outcomes

Experience, views and satisfaction of people in transition and their carers
Quality of life
Independence, choice, and control
Continuity of care
Suicide rates

Years of life saved
Cost-effectiveness

Service Outcomes

Use of mental health and social care services
Need for unpaid care and support
Length of inpatient stay
Delayed transfers from inpatient mental health settings
Admission to residential or nursing care
Unplanned or inappropriate inpatient admissions
Hospital re-admissions

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health. See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Search Strategies

The evidence reviews used to develop the guideline recommendations were underpinned by systematic literature searches, following the methods described in *Developing NICE guidelines: the manual* (see the "Availability of Companion Documents" field). The aim of the systematic searches was to comprehensively identify the published evidence to answer the review questions developed by the Guideline Development Group and NICE Collaborating Centre for Social Care.

A single search strategy for the review questions was developed by the NICE Collaborating Centre for Social Care. The research questions were translated into a framework of three concepts of: a) settings or populations (mental health inpatient settings, or hospitalised patients with mental disorders), and b) processes ('transition', discharge or admission) and c) study design (qualitative studies; studies on people's views and experiences; controlled trials or studies with comparison groups, and economic evaluations and systematic reviews and meta-analyses).

These concepts were translated into search strategies using subject heading and free text terms. The strategies were run across a number of databases. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology. Terms on leaving or returning to home or community settings were used to capture transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care were used to capture literature about system-level transitions. The search was restricted to studies published from 1999 onwards. This is on the basis that it was the year of publication for the National Service Framework for Mental Health with new set standards and a ten year agenda for improving mental health care and also established three community mental health teams. Citations published in non-

English language were limited within several data bases (CINAHL, EMBASE, MEDLINE, PsycINFO and SSCI). Additional searches of Web sites of relevant organisations and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases: National Health Services Economic Evaluation Database (NHS EED); Econlit; Cost-effectiveness Analysis Registry (CEA Registry); and IDEAS RePEc.

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The searches were undertaken between January 2015 and March 2015. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies. Update searching of the bibliographic databases searches is scheduled for March 2016.

Main Searches

The following sources were searched for the topics presented in the guideline.

Bibliographic Database Searches

ASSIA (Proquest)
British Education Index (BEI) (EBCSO)
British Nursing Index (HDAS)
CINAHL (EBSCO)
Cochrane Library (CENTRAL trials, Systematic reviews)
Conference Proceedings Citation Index (CPCI) (Social Sciences and Humanities) (Web of Knowledge) (2011-onwards only)
Database of Abstracts of Reviews of Effects (CRD platform)
ECONLIT (EBSCO)
EMBASE (OVID SP)
Educational Information Resources Center (ERIC) (EBSCO)
Health Management Information Consortium (OVID SP)
Health Technology Assessment (HTA) Database (CRD platform)
International Bibliography of the Social Sciences (IBSS) (Proquest)
Medline (EBSCO)
NHS Economic Evaluation Database (NHS EED) (CRD platform)
PsycINFO (OVID SP)
Social Policy and Practice (SPP) (OVID SP)
Social Science Citation Index (Web of Knowledge)
Social Services Abstracts (Proquest)
Social Work Abstracts (OVID SP)
Sociological Abstracts (Proquest)

Refer to the "Search Strategies" companion document (see the "Availability of Companion Documents" field) for information on other Web sites, trials registries and databases searched.

Number of Source Documents

Database searches identified 28,072 studies. Additional items from supplementary searches, including Web sites totalled another 438 studies. A total of 67 studies were included in the review for critical appraisal and data extraction.

Refer to the "Search Strategies" companion document (see the "Availability of Companion Documents" field) for a flowchart summarising excluded studies and study selection and information on search strategies and search terms.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality Ratings for Individual Studies

Studies were rated for internal and external validity using ++/+/- (meaning good, moderate and low).

++ All or most of the checklist criteria have been fulfilled, and where they have not been fulfilled the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled, and where they have not been fulfilled, or are not adequately described, the conclusions are unlikely to alter.

- Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health. See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

When this guideline was started, the Guideline Committee used the methods and processes described in the Social Care Guidance Manual (2013). From January 2015, the methods and processes in Developing NICE Guidelines: The Manual (2014) were used (see the "Availability of Companion Documents" field).

The included studies were critically appraised using tools in the manuals and the results tabulated (see Appendix B for tables). Minor amendments were made to some of the checklists to reflect the range of evidence and types of study design considered in the evidence reviews. For more information on how this guideline was developed, including search strategies and review protocols, see Appendix A.

Rating the included studies was complex as the 'best available' evidence was often only of moderate quality. Studies were rated for internal and external validity using ++/+/- (meaning good, moderate and low). Where there are 2 ratings (for example +/-), the first rating applies to internal validity (how convincing the findings of the study are in relation to its methodology and conduct). The second rating concerns external validity (whether it is likely that the findings can be applied to similar contexts elsewhere). The internal quality rating is given in the narrative summaries and evidence statements with both the internal and external rating reported in the evidence tables in Appendix B.

The critical appraisal of each study takes into account methodological factors such as:

- Whether the method used is suitable to the aims of the study
- Whether random allocation (if used) was carried out competently
- Sample size and method of recruitment
- Whether samples are representative of the population the authors are interested in
- Transparency of reporting and limitations that are acknowledged by the research team

Evidence rated as of only moderate or low quality may be included in evidence statements, and taken into account in recommendations, because the guideline committee independently and by consensus

supported its conclusions and thought a recommendation was needed.

For full critical appraisal and findings tables, arranged alphabetically by author(s), see Appendix B.

Economic studies, in addition to being rated for their internal and external validity, have also been rated for their applicability (applicable, partially applicable, not applicable) and rated for their economic methodological quality (very serious limitations, potentially serious limitations, minor limitations). Methodological appraisal detailing the limitations of these studies is fully described in Appendix C1.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health. See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

When this guideline was started, the Guideline Committee used the methods and processes described in the Social Care Guidance Manual (2013). From January 2015, the methods and processes in Developing NICE Guidelines: The Manual (2014) were used (see the "Availability of Companion Documents" field).

The review questions examining effectiveness of different interventions and approaches are used as the themes for the review areas reported (for example, admissions into inpatient mental health settings, transitions in and out of inpatient mental health for children and young people with mental health problems). For every review area, the Guideline Committee also sought evidence on views and experiences relating to the different approaches or interventions. The result is that for each review area reported, evidence is presented from studies of effectiveness and from studies of views and experiences as they relate to that review area. Where relevant, evidence from economics studies is also reported.

The same views and experiences questions were applied for every review area, so as to supplement the more measurable data on effects. The views and experiences review questions which delivered material to supplement effectiveness studies are:

1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings?

2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?

3. (a) What are the views and experiences of health, social care and other practitioners (for example, in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?

3. (b) What are the views and experiences of health, social care and other practitioners (for example, in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?

Due to the interrelatedness of some of the review areas, evidence was found to be overlapping. This was particularly so for the hospital discharge and reducing readmissions review areas. As the review work progressed through the development phase, the Guideline Committee had an increasing body of evidence on which to develop recommendations. They were able to consider findings from 1 review area and apply them to the refinement of recommendations in other areas. Where evidence from 1 review area was used to inform recommendations in another area, this is described in Section 3, in the full version of the guideline, including the 'Linking evidence to recommendations' tables.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

Some recommendations can be made with more certainty than others, depending on the quality of the underpinning evidence. The Guideline Committee makes a recommendation based on the trade-off between the benefits and harms of a system, process or an intervention, taking into account the quality of the underpinning evidence. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The Guideline Committee usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the Guideline Committee uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The Guideline Committee uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of people, a system, process or an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the Guideline Committee is confident that an intervention will not be of benefit for most people.

Interventions That Could Be Used

The Guideline Committee uses 'consider' when confident that a system, process or an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Cost Analysis

Economic Work as Part of Guideline Development

The economic work is comprised of 2 main components. The first is the critical appraisal and review of existing cost-effectiveness literature and interpreting the results to make recommendations for the UK context. These can be found in Appendices C1 and C2 of the full version of the guideline (see the "Availability of Companion Documents" field). The second component is undertaking new economic analyses. Those new analyses are presented in economic Appendices C3.2 and C3.3 (see the "Availability of Companion Documents" field).

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Commenting on the Draft Guideline

The draft version of the guideline is posted on the National Institute for Health and Care Excellence (NICE) Web site for consultation with registered stakeholders and respondents. Stakeholders can register at any point during guideline development. NICE informs registered stakeholders and respondents that the draft is available and invites them to comment by the deadline. Questions for stakeholders are posted with the draft guideline. The purpose of these questions is to seek stakeholder views on factors such as the potential equality impact. NICE also asks stakeholders to comment on recommendations identified as likely to substantially increase costs, and their justification, and to consider whether any other draft recommendations are expected to add substantial costs.

Principles of Responding to Stakeholder Comments

After consultation the Committee discusses the comments received during consultation, proposes any changes needed to the guideline, and agrees the final wording of the recommendations.

Developers must take the following key points into account when responding to comments from registered stakeholders:

- Each comment must be acknowledged and answered as directly, fully and with as much information as possible.
- For a draft guideline, the Committee must consider whether changes to the guideline are needed as a result of consultation comments; any changes to the guideline must be agreed by the Committee before publication.
- If changes are made to a guideline as a result of a consultation comment, this must be made clear in the response to the comment. If no changes have been made, it should be clear from the response why not.
- Developers should maintain an audit trail of any changes made to the guideline.

Registered stakeholders who have commented on the draft guideline are sent the final guideline, in confidence 2 weeks before publication (see chapter 11). Comments and responses are made available on the NICE Web site when the final guideline is released.

Comments received from nonâ€˜registered stakeholders and individuals are reviewed by the Committee. A formal response is not given and these comments are not made available on the NICE Web site. However, if they result in changes to the guideline this is recorded in the Committee meeting minutes.

Comments received after the deadline are not considered and are not responded to; in such cases the sender will be informed.

Refer to "Developing NICE guidelines: the manual" (see the "Availability of Companion Documents" field) for additional information.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The type of evidence supporting each review area is detailed in the full version of the guideline (see the "Availability of Companion Documents" field).

Benefits/Harms of Implementing the Guideline

Recommendations

Potential Benefits

- Improved patient experience during transition between inpatient mental health settings and community or care home settings
- Improved practice among professionals involved in transition processes and cross-sector working

Refer to the "Trade-off between benefits and harms" sections of the full version of the guideline (see the "Availability of Companion Documents" field) for details about benefits of specific interventions.

Potential Harms

- The potential loss of support from carers, friends and family; the cost (including time) of transport for visitors; and the effects of not being able to engage in social, educational and employment activities were all considered as potential harms for people placed out-of-area. The increased risk of suicide for people placed out-of-area is of particular concern.
- It was recognised by individual members of the Guideline Committee that peer support could have adverse outcomes. Peer supporters (whether formally employed or not) might experience a decline in their own mental health due to the additional responsibility; they might also have an adverse impact on the person being supported. Recruitment, training and supervision might mitigate the likelihood of such outcomes.

See the "Trade-off between clinical benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for details about harms of specific interventions.

Qualifying Statements

Qualifying Statements

- The recommendations in this guideline represent the view of the National Institute for Health and Care Excellence (NICE), arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.
- Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.
- Although most of the recommendations in this guideline cover both planned and unplanned admissions, some (like those on pre-admission planning) are only applicable to planned admissions. If an admission is unplanned, then these recommendations should be applied at the soonest possible point after admission, if appropriate to the person's individual circumstances.
- This guideline has been developed in the context of a complex and rapidly evolving landscape of guidance and legislation, most notably the Care Act 2014.
- Refer to the "Context" section in the full version of the guideline (see the "Availability of Companion

Documents" field) for additional details on how various legislation and policies affect the guidance.
- See the "Person-centred care" section in the full version of the guideline for information about individual needs and preferences and transition of care.

Implementation of the Guideline

Description of Implementation Strategy

Implementation: Getting Started

This section of the original guideline document highlights three areas of the transition between inpatient mental health settings to community and care home settings that could have a big impact on practice and be challenging to implement, along with the reasons why change needs to happen in these areas.

Refer to the original guideline document for additional information on these three areas of transition:

Delivering services that are person-centred and focus on recovery
Ensuring effective communication between teams, and with people using services and their families and carers
Co-producing comprehensive care plans that meet people's changing needs

Implementation Tools

Clinical Algorithm

Foreign Language Translations

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Transition between inpatient mental health settings and community or care home settings. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug 30. 34 p. (NICE guideline; no. 53).

Adaptation

Not applicable: The guideline was not adapted from another source.

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Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

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National Institute for Health and Care Excellence (NICE)

Guideline Committee

Guideline Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

See Section 7 in the full version of the guideline (see the "Availability of Companion Documents" field) for declarations of interests made by the members of the Guideline Committee.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the National Institute for Health and Care Excellence (NICE) Web site . Also available for download in ePub or eBook formats from the NICE Web site .

Availability of Companion Documents

The following are available:

Transition between inpatient mental health settings and community or care home settings. Full guideline. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug. 345 p. (NICE guideline; no. 53). Available from the National Institute for Health and Care Excellence (NICE) Web site .

Transition between inpatient mental health settings and community or care home settings. Appendices A-D. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug. (NICE guideline; no. 53). Available from the NICE Web site .

Transition between inpatient mental health settings and community or care home settings. Search strategies. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Feb. (NICE guideline; no. 53). 104 p. Available from the NICE Web site .

Transition between inpatient mental health settings and community or care home settings. Baseline assessment tool. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug. (NICE guideline; no. 53). Available from the NICE Web site .

Transition between inpatient mental health settings and community or care home settings. Resource impact tool. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug. (NICE guideline; no. 53). Available from the NICE Web site .

Developing NICE guidelines: the manual. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Oct. 240 p. Available from the NICE Web site .

Patient Resources

The following is available:

Transition between inpatient mental health settings and community or care home settings. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug. 7 p. (NICE guideline; no. 53). Available in English and Welsh from the National Institute for Health and Care Excellence (NICE) Web site. Also available for download in ePub or eBook formats from the NICE Web site .

NGC Status

This NGC summary was completed by ECRI Institute on December 23, 2016.

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